



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BELLMAR ASC, LLC
325 SOUTH TELLER STREET SUITE 200
DENVER COLORADO 80226

Respondent Name

INSURANCE CO OF THE STATE OF P

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2915-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was denied for timely filing "After" 95 days from service date. I am appealing denial based on the following. We submitted the claim to WC/Corvel on 10/05/10. We contacted Corvel on 11/09/10 spoke w/Mona who stated that our claim was In review from 10/08/10. We gain followed up w/ Corvel on 11/09/10 spoke w/CSR Marsha who stated at that time...there was not a claim on file from us...We faxed the claim w/all required medical documentation to F#: 888-530-3852. On 11/29/10 again checking claim status w/Corvel spoke w/Brian who stated the claim was in process as of 11/19/10. Checking claim again on 12/20/10 w/Corvel, spoke w/Erica who "emailed " the bill/claim to review placing a "Rush" on this claim. We then receive a request dated: 01/19/11, that the "Facility" charges be placed on a HCFA claim form, sighting this is a Texas WC claim & the charges need to be on a HCFA. Please Note: All ASC's & Hospitals bill on a UB04 this is standard practice. We conform to this request & forward the ASC claim to Corvel on the Requested HCFA claim form only to receive a denial stating this claim has been denied for "timely filing" We submitted the claim to Corvel within the timely filing limits more than twice. After being in contact w/Corvel numerous times... They wait 4 months to notify us that this is a Texas WC claim & needs to be billed on a HCFA claim form? I have included w/in this email, all of our system documentation, claim history, fax fwd to Corvel on 11/19/10 & the correspondence received from Corvel along w/the denial. I have contacted the patient & I have also forwarded a Formal Appeal/Complaint w/the state of Colorado WC Division. Please contact me directly at your earliest opportunity to discuss this appeal in further detail. "

Amount in Dispute: \$2,365.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has failed to submit convincing evidence of the timely submission. Accordingly, the carrier submits that the requestor is not entitled to any reimbursement due to the failure to timely submit a bill."

Response Submitted by: Insurance Company of the State of PA Flahive Ogden & Latson 504 Lavaca Suite 1000 Austin TX 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23,2010	Ambulatory Surgical Center Services	\$2,365.58	\$

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for health care providers required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-commission Communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated 03/01/2011
 - 29 Time Limit for filing Claim/Bill has Expired
 - RM2 Time limit for filing claim has expired
 - Effective 9/1/05, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit. Reimbursement is denied in accordance with Section 408.027 of the Act.
 - There was no "denial" EOR attached. The Bill is deemed incomplete until submitted on the correct form. This does not negate the requirement of the HCP to submit the bill within 95 days.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Texas Administrative Code §133.20?
3. Did the requestor submit documentation to support the disputed bills were submitted timely and in accordance with Texas Labor Code, §408.027 and Texas Administrative Code §133.10 and §102.4.
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided services in the state of Colorado on September 23, 2010 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of non-payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. Per 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that the exceptions indicated in Texas Labor Code §408.0272 were met. Therefore, Texas Labor Code §408.0272 does not apply to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to submit the medical bill no later than 95 days after the service in dispute was provided. Texas Administrative Code §102.4(h) "unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next

previous day which is not a Sunday or legal holiday.”

3. Review of the documentation submitted by the Requestor finds a notice of incomplete bill from carrier dated 01/19/2011, Copy of UB 04 with creation date 10/05/2010, copy of CMS 1500 with signed date 02/01/2011, EOB with MBR date 02/10/2011 and insurance claim information system log notes.
4. In Accordance with Tex. Lab. Code Ann. §408.027, documentation submitted by the requestor in this medical fee dispute does not support that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee. Therefore, payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	December 28, 2011 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.